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In The

Supreme Court of the United States

October Term, 1992

RICHARD A. WOLFF AND MARGUERITE M. WOLFF,
Petitioners,

vs.

LIFE INSURANCE COMPANY OF NORTH AMERICA, a Pennsylvania Corporation and JOHNSON & HIGGINS, a Foreign Corporation,

Respondents.

Petition for Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

PETITION FOR WRIT OF CERTIORARI

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69 pp

QUESTIONS PRESENTED

1. Whether the Sixth Circuit's decision in this case improperly overrules its own prior decision in *Norfolk & Western Railway Co. v. Auto Club Insurance Association*, 894 F.2d 838 (6th Cir. 1990), and misapplies Michigan law by holding that periods of limitation for filing insurance claims cannot be tolled by the filing of related claims which put the insurer on notice of its potential liability.

2. Whether the Sixth Circuit's decision in the case at bar wholly vitiates the Congressional intent of the Employee Retirement Income Security Act, 29 U.S.C. § 1001 *et seq.*, by protecting the interests of the insurer and employer to the complete detriment of the petitioner-employee in a case where the facts and equities are clearly with petitioner and where application of the Congressional intent is clearly mandated.

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OPINIONS BELOW

The report and recommendation of the United States Magistrate is not reported but is reproduced in Appendix E (17a-33a). The opinion of the United States Court of Appeals for the Sixth Circuit is reported as a Table Case at 989 F.2d 501 and is reported in full at 1993 U.S. App. LEXIS 6903. It is reproduced in Appendix B (2a-13a).

STATEMENT OF JURISDICTION

The judgment of the United States Court of Appeals for the Sixth Circuit was entered on March 23, 1993 (App. B at 2a-13a). The order of the United States Court of Appeals for the Sixth Circuit denying petition for rehearing was entered on April 16, 1993 (App. A at 1a). Jurisdiction of this court is based on Rule 10.1(a) of the Rules of the Supreme Court.

STATEMENT OF THE CASE

Richard Wolff was an active combatant in World War II. While stationed on the Island of Saipan in 1945, he was injured by an artillery explosion. As a result of the explosion, he was rendered deaf in one ear for a period of approximately eight months. He also sustained a permanent injury to his left eye in the nature of exotropia, *i.e.*, the eye permanently turns out (R. 27: Richard A. Wolff Deposition, pp. 10, 11 and 12). He also suffered from severe post traumatic cephalgia for a period of eleven years. Since 1956, he has been asymptomatic in that regard.

Commencing three weeks after his medical discharge in 1946 through 1966, Mr. Wolff was engaged in a variety of positions relating to the insurance trade (R. 27: Richard A. Wolff Deposition, pp. 24-32). In 1966, he became employed by Johnson & Higgins and in 1969 became a property loss consultant. As Johnson & Higgins indicated in its brief filed in the Eastern District of Michigan, Southern Division, Mr. Wolff's job duties as a consultant:

> were to analyze existing property insurance rates and establish tentative rates for new locations. This work involved inspection of the client's premises and then application of approximately 300 pages of ratings guidelines

> to the specific characteristics of the client's property. In addition to the physical demands of the inspection duties involved in the job, mathematical accuracy was also a prerequisite

(R. 18: Johnson & Higgins' Brief, pp. 4-5).

At no time prior to the injury giving rise to this litigation has Richard Wolff ever suffered from either a short-term memory loss or a cognitive dysfunction, *i.e.*, an inability to think properly. This is borne out by Johnson & Higgins' description of the complexities of his job and also by Mr. Wolff's deposition testimony, his wife's, and by the complete absence of any references in his medical or employment records which would indicate that he suffered from either of those disabilities prior to his injury in 1980.

On March 18, 1980, during the course of his employment with Johnson & Higgins, Mr. Wolff tripped and fell face first on a sidewalk in Kentwood (Grand Rapids), Michigan, as a result of which he fractured his nose and suffered severe and permanent brain injuries (R. 27: Richard A. Wolff Deposition, pp. 50-51). On the day of the incident, Mr. Wolff was able to telephone his employer and advise Ed Baresa, a management level employee of Johnson & Higgins, of his injury (R. 27: Richard A. Wolff Deposition, pp. 73-74). Within seven days Mr. Wolf reported back to work, at which time it was apparent that he had been involved in a serious accident. As both respondents readily conceded in the district court, Mr. Wolff's short-term memory and cognitive abilities began to significantly deteriorate after his fall. In fact, from March 18 until his forced retirement on October 1, 1980, Mr. Wolff was never again an effective employee of Johnson & Higgins.

Compelling examples of Richard Wolff's loss of short-term memory and cognitive reasoning are set forth in his deposition

transcript (R. 27: Richard A. Wolff Deposition, pp. 70 and 108). There he describes dressing for work on one occasion and driving to downtown Detroit only to discover that he had dressed for work with a suit and tie but had neglected to put on his shirt and, in another instance, had shaved one side of his face but had neglected to shave the other. His recollection of these episodes resulted in momentary breakdowns during the deposition. Another example of his short-term memory loss and of the deterioration in his cognitive abilities was made manifest when counsel for LINA requested Mr. Wolff's social security number. Mr. Wolff could not recall the number and reached into his pocket to remove his wallet, obviously to get his social security card. When the wallet was in mid-air, Mr. Wolff became distracted. When he noticed his hand suspended with the wallet in mid-air, he asked why he had his wallet out and when reminded of the reason why, he broke down yet again (R. 27: Richard A. Wolff Deposition, pp. 6-7).

No evidence exists to refute the allegation that the conditions which manifested themselves after March 18, 1980, are attributable in whole, or in part, to any prior existing condition.[1] Both respondents received actual knowledge of Mr. Wolff's condition after March 18. Johnson & Higgins received telephone notice and visual confirmation of Richard Wolff's condition. The Life Insurance Company of North America (LINA) processed Mr. Wolff's claim for permanent, total, long-term disability benefits and determined that he was so disabled as a result of the March 18 episode. LINA investigated the incident and received annual medical reports of Mr. Wolff's condition for each year long-term disability benefits were paid by it to him from 1980 until 1990.

Among the benefits which Mr. Wolff was to receive as an

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1. Respondents, however, do allege that Mr. Wolff's World War II injuries contributed in part to his present disability.

employee of Johnson & Higgins were the ERISA benefits contained in three LINA insurance policies, two of which are the subject of this litigation. The first of the three LINA policies was a group long-term disability plan pursuant to which LINA paid long-term disability benefits to Mr. Wolff as a result of the incident giving rise to this litigation. The latter two insurance policies were LINA's Personal Injury Accident Policy number ABL-61-3606 and its Business Travel Accident Policy number OK-20-33. The premiums for the business accident policy were paid by Johnson & Higgins. Payroll deductions were utilized for payment of the personal accident policy premiums. The total benefit to be paid pursuant to the two policies was $180,000 upon Mr. Wolff's total and permanent disability by accident.

When Mr. Wolff returned to work shortly after the incident of March 18, 1980, his rapidly deteriorating mental condition made it apparent to Johnson & Higgins that forced retirement was inevitable. On August 28, 1980, Elaine M. Justus, assistant vice president of Johnson & Higgins, wrote to Mr. Wolff advising him of certain benefits which might be available to him because of his condition (App. F, Letter of August 28, 1980 from J & H to Richard Wolff, pp. 34a-35a). While the letter does not refer to the basis for his disability, there can be no doubt that the disability was related to his mental condition. The letter identifies two potential avenues of recovery for Mr. Wolff, one being long-term disability benefits and the other being social security disability benefits. The letter is silent as to whether the types of potential claims suggested in the letter were meant to describe all potential claims available to Mr. Wolff, or not. Likewise, the letter is silent as to whether Johnson & Higgins was sending this letter to Mr. Wolff because it was assuming a duty to advise its brain injured employee or whether it was fulfilling an existing duty imposed upon it either as an agent of the insurer (LINA) or as Mr. Wolff's agent *vis-a-vis* the insurer.

Total and permanent disability benefits were received from

the Social Security Administration upon application. On March 13, 1981, Ms. Justus executed a proof of loss form on behalf of Johnson & Higgins for submission to LINA for the LINA long-term disability policy (R. 30: Combined Brief in Support of Answer to Motions for Summary Judgment). The March request resulted in payment of long-term disability benefits. On August 20, 1981, Ms. Justus remitted LINA's first check and its computation for long term disability benefits to Mr. Wolff (R. 59: Johnson & Higgins' Transmittal Letter dated August 20, 1981).

In both instances where Johnson & Higgins suggested to Richard Wolff that applications for benefits be made, applications were made and benefits were paid. The only known benefits which could have been obtained as a result of the March 18, 1980, incident which were not obtained were those of which Johnson & Higgins failed to advise Richard Wolff.

Mr. Wolff was retired October 1, 1980. This is confirmed in Johnson & Higgins' December 29, 1980, letter to Mr. Wolff which misstates that his personal accident insurance benefits had "stop[ped] at retirement" and failed to mention at all the business accident insurance coverage, both of which coverages were available to Mr. Wolff (App. G: Letter of December 29, 1980, from J & H to Richard Wolff, pp. 36a-39a). It is indisputable that, had LINA processed a claim under both policies, $180,000 would have been paid.

Year after year, until age 65, Mr. Wolff continued to submit to annual medical examinations at LINA's request and continued to receive long-term disability benefits for his total and permanent disability. In December of 1988, prior to Mr. Wolff's 65th birthday, a letter was sent by Johnson & Higgins to Mr. Wolff. The letter, which was sent to advise Mr. Wolff of possible changes in benefits as a result of his attaining age 65, apparently jogged his memory about the Johnson & Higgins' benefits book (R. 27: Richard A. Wolff Deposition, pp. 42 and 76).

Promptly upon discovering the existence of these policies, claims were filed with LINA which resulted in letters to Mr. Wolff dated February 5, 1990, from Johnson & Higgins and May 8, 1990, from LINA denying his claims for benefits (R. 30: Combined Brief in Support of Answer to Defendants' Motions for Summary Judgment). The only reason asserted in the letters for denying his claims was that Mr. Wolff's condition did not result solely from an accident. In other words, LINA asserted that Mr. Wolff's World War II injuries had somehow contributed to his total and permanent disability. As previously indicated, there is no medical evidence which substantiates that assertion.

Upon denial of the claim and rejection of counsel's request for reconsideration, suit was filed in state court on June 1, 1990 (R. 1: Complaint). The matter was removed to the district court by notice of removal, dated July 9, 1990 (R. 1: Complaint). Thereafter the depositions of Mr. and Mrs. Wolff were taken.

Respondents then filed motions for summary judgment and for dismissal on January 30, January 31 and February 4, 1991 (R. 17, 18, 19, 20, 21, 22, 23 and 25). Petitioners filed their responses on February 25, and February 28, 1991 (R. 30 and 31). The matter was referred to the Magistrate.

While numerous issues were raised in the motions, particularly the statute of limitations, the Magistrate recommended summary judgment for respondent LINA because of a contractual period of limitations contained in each of the policies and recommended dismissal of Johnson & Higgins because it had no ERISA imposed fiduciary duties (R. 38 Report and Recommendation of United States Magistrate). The contractual period of limitations was neither briefed nor argued by the parties. The provisions in which the limitations language is contained is identical in both policies: "No such action shall be brought after the expiration of three years after the time written

proof of loss is required to be furnished." (R. 20: Johnson & Higgins 3rd Motion for Summary Judgment).

The Magistrate filed his report and recommendation on September 10, 1991 (R. 38: Report and Recommendation of United States Magistrate). Petitioners filed objections on September 24, 1991 (R. 39: Objections to Report and Recommendation of United States Magistrate). After argument before the district court, both an acceptance of the report and recommendation and a judgment were entered December 13, 1991 (R. 43 and 44). Timely notice of appeal was filed January 9, 1992 (R. 45: Appeal of Order). On March 23, 1993, the Court of Appeals for the Sixth Circuit affirmed the district court's decision, and on April 5, 1993, Mr. Wolff filed a petition for rehearing. On April 16, 1993, Mr. Wolff's petition for rehearing was denied.

REASONS FOR GRANTING THE WRIT

I.

WHETHER THE SIXTH CIRCUIT'S DECISION IN THIS CASE IMPROPERLY OVERRULES ITS OWN PRIOR DECISION IN *NORFOLK & WESTERN RAILWAY CO. V. AUTO CLUB INSURANCE ASSOCIATION,* 894 F.2d 838 (6TH CIR. 1990), AND MISAPPLIES MICHIGAN LAW BY HOLDING THAT PERIODS OF LIMITATION FOR FILING INSURANCE CLAIMS CANNOT BE TOLLED BY THE FILING OF RELATED CLAIMS WHICH PUT THE INSURER ON NOTICE OF ITS POTENTIAL LIABILITY.

The Court of Appeals for the Sixth Circuit, in its opinion in the case at bar, has misapplied Michigan law and thereby improperly overruled its own prior decision by holding that insurance

companies never have a duty to inform insureds they are eligible to receive benefits from multiple policies when the insurance company has received notice of injury under a single policy. The appellate court based its decision on one Michigan case, citing it as controlling, while ignoring a more recent Sixth Circuit case and several subsequent Michigan cases which are clearly apposite to the issue of notice and contrary to the holding of the Court of Appeals in this case.

Petitioners' basic assertion is that because they processed a claim for long-term disability benefits through respondent LINA, LINA is estopped from asserting lack of notice and is thereby estopped from asserting the contractual period of limitations as a bar to petitioners' later claims under separate policies. The appellate court noted that the Michigan Supreme Court addressed a notice of injury issue in *Welton v. Carriers Insurance Co.*, 421 Mich. 571 (1984). In that case, an insurance carrier provided the plaintiff's employer with both worker's compensation insurance and no-fault automobile insurance. The plaintiff was injured and submitted a worker's compensation claim. Later, the plaintiff filed a claim for no-fault automobile insurance benefits, arguing that the running of the statute of limitations should have been tolled because the filing of the worker's compensation claim provided sufficient notice to the carrier of the remaining claim. The Michigan Supreme Court disagreed, holding that the notice of injury provided by the timely filing of the worker's compensation claim was insufficient to toll the statute for a no-fault automobile insurance benefits claim. The Court of Appeals for the Sixth Circuit found this passage from *Welton* particularly apt, and applied it directly to petitioners' case in its opinion:

> Notice of injury simply informs the insurer of "the name and address of the claimant," "the name of the person injured and the time, place and nature of his injury", M.C.L. 500.3145(1);

> M.S.A. 24.13145(1). Until a specific claim is made, an insurer has no way of knowing what expenses have been incurred, whether those expenses are covered losses and, indeed, whether the insured will file a claim at all. It is therefore illogical to expect the insurer to formally "deny" an as yet unperfected claim.

421 Mich. at 579 (1984). The Court of Appeals thus held that a specific claim for damages was necessary to toll the running of the statute of limitations.

Contrary to the holding of the Court of Appeals for the Sixth Circuit, *Welton* is no longer dispositive of this issue. *Welton* appeared to be on point because it bore some resemblance to the case at bar on a factual level. In *Welton,* the insurer handled both worker's compensation and no-fault insurance for the employer. In the case at bar, respondent-insurer provided, in addition to Mr. Wolff's long-term disability policy, personal injury protection and business travel injury protection policies. In both cases a single insurance carrier was responsible for the administration of all of the policies in controversy. Both cases involve questions of notice and tolling of the applicable periods of limitation for the filing of insurance claims. There the resemblance ends.

Welton argued that submitting a worker's compensation claim was notice sufficient to trigger the tolling of the statute of limitations on his no-fault claim. The appellate court's decision in the case *sub judice* reasoned by analogy that since the facts in *Welton* and petitioners' case appeared to be similar, the no-fault notice rule is applicable to Mr. Wolff. Its conclusion was that if the filing of a worker's compensation claim was insufficient to trigger tolling for a no-fault claim, then neither would the filing of a claim for long-term disability benefits be an event sufficient to trigger tolling for the filing of claims under personal injury and travel

accident insurance policies. Therefore, it reasoned, specific claims for each policy are required before the contractual periods of limitation can be tolled.

The appellate court's reasoning and conclusion are unsound. *Norfolk & Western Railway Co. v. Auto Club Insurance Association,* 894 F.2d 838 (6th Cir. 1990), a case also decided by the Court of Appeals for the Sixth Circuit, clearly states that specific claims for each policy need not be filed to trigger tolling: "[T]he rule in *Welton* that tolling is triggered by a specific claim for benefits applies only in cases under [MCLA] section 3145(1) involving personal injuries . . ." 894 F.2d at 841 (6th Cir. 1990). Section 3145 relates to automobile no-fault insurance benefits. The Sixth Circuit has already ruled that the strict requirements of *Welton* apply *only* to cases involving claims for personal injury no-fault automobile insurance benefits. Petitioners are not seeking benefits under a no-fault policy, but under group personal accident and business travel accident policies. *Welton's* test does not apply to petitioners' claims.

The Michigan Supreme Court understood this vital distinction. In the *Welton* opinion, that court said, "[W]e note that our determination today . . . is justified by the peculiar nature of the statutory no-fault limitation provision [in MCLA 500.3145(1). . .]." 421 Mich. at 580 (1984). Additionally, the *Welton* court stated its firm intent not to foreclose the possibility of some later claim triggering tolling "under circumstances not before us today." *Id.* at 581. The Michigan court recognized that it would be intemperate to make the kind of sweeping pronouncement the appellate court made in the case at bar. *Welton* merely offers a rule which meets the needs of its unique circumstances and leaves future courts the ability to decide original issues of notice as they arise.

Ultimately, even if this Honorable Court were to find the Sixth

Circuit's application of Michigan's no-fault notice rule to petitioners' case a proper exercise of judicial discretion, the court of appeals drew the wrong conclusion when it stated that petitioners' notice was insufficient to trigger tolling. This is shown by several recent Michigan cases which develop *Welton's* notice rule, both from a no-fault automobile insurance perspective and from a personal injury benefits perspective.

State Farm Mutual Automobile Insurance Co. v. Insurance Co. of North America, 166 Mich. App. 133 (1988) involved facts identical to those of *Welton:* defendant Insurance Co. of North America (INA) provided plaintiff's employer with both worker's compensation insurance and no-fault automobile insurance. The plaintiff was injured and filed a worker's compensation claim. Later he argued that filing his worker's compensation claim was notice sufficient to apprise INA of the no-fault claim. The Michigan Court of Appeals agreed:

> In *Spayde v. Advanced Foam Systems, Inc.*, 124 Mich. App. 454; 335 N.W. 2d 1 (1981), this Court held that notice of a claim for worker's compensation benefits made to an employer's worker's compensation carrier did not constitute "notice of injury" within the meaning of MCL 500.3145(1); MSA 24.13145(1), when the worker's compensation carrier was also the employer's no-fault insurer.
>
> In light of the Supreme Court's discussion in *Welton,* we are persuaded that the *Spayde* analysis inappropriately blurs the distinction between the statutory notice of injury and a claim for specific benefits. . . . We agree with Justice Levin's separate opinion in *Welton:*

> [T]he only reason why an injured worker who has filed a claim for worker's compensation benefits would not at the same time file a claim for the additional amount due him as no-fault benefits would be ignorance of his entitlement thereto or of the procedure to be followed in seeking the additional money that the insurer owes him.

166 Mich. App. at 139-141 (1988).

In overruling *Spayde* and giving the weight of authority to Justice Levin's separate opinion in *Welton*, the Michigan Court of Appeals has rejected that portion of *Welton* upon which the Sixth Circuit depended so heavily in holding against petitioners. The law is now clear in Michigan: a claim for specific benefits is not necessary to trigger tolling. A claim for worker's compensation benefits is notice sufficient to trigger tolling when the insurer also supplies the insured with a no-fault policy. Applying the same reasoning the Court of Appeals for the Sixth Circuit used, if such a claim were sufficient to trigger tolling in a no-fault case, it must also trigger tolling in the case at bar.

The case at bar parallels *State Farm Mutual Automobile Insurance Co. v. Insurance Co. of North America*, 166 Mich. App. 133 (1988) in another important aspect: the defendant in that case, INA, is a sister subsidiary of respondent LINA in the case *sub judice*. Respondent utilized the same notice argument in *State Farm* that it depends on now and lost the *State Farm* case; if the law went against respondent's position then, the law should refute the identical position now.

Johnson v. State Farm Mutual Automobile Insurance Co., 183 Mich. App. 752 (1990) is also directly on point and conclusively

supports petitioners' position. In that case, the plaintiff's husband, while riding a motorcycle, was struck and killed by an uninsured motorist. Plaintiff's decedent was eligible for benefits under two policies plaintiff had purchased, one for the motorcycle and one for another vehicle he owned. Plaintiff filed a timely claim under the motorcycle policy and later argued that the filing of that claim was sufficient notice to trigger tolling of the statute of limitations on the second policy. Again, the Michigan Court of Appeals agreed:

> The case at bar is on all fours with this Court's decision in *State Farm Mutual Automobile Ins. Co. v. Ins. Co. of North America,* 166 MichApp 133; 420 NW2d 120 (1988).
>
> Section 3145 specifically states what must be contained in a notice of injury: namely, the name and address of the claimant, plus a description in ordinary language of the name of the person injured and the time, place and nature of the injury. As noted by the *State Farm* Court, the statute does not . . . provide that the notice of injury must specifically identify under which insurance policies the claimant is claiming benefits. To accept defendant's theory, we would have to conclude that plaintiff was obligated to tell her insurance agent about her loss twice . . . Such a requirement is absurd.
>
> [We conclude] that plaintiff filed a sufficient notice of injury with defendant to toll the period of limitations set forth in § 3145(1) . . .

183 Mich. App. at 756-59.

The reasoning of the Michigan Court of Appeals demonstrates

the overreaching of the Court of Appeals for the Sixth Circuit. The following passage evidences the error of the Sixth Circuit, which requires the granting of a writ of certiorari:

> Although the Supreme Court in . . . *Welton*, supra, makes reference to a claimant's making a "specific claim for benefits," their opinions do not define what constitutes a "specific claim for benefits" for purposes of tolling . . . We conclude that the actions taken by plaintiff in the case at bar were sufficient to toll the one year back rule.
>
> Defendant would have us conclude that, in order to apply the tolling provisions . . . it is necessary that plaintiff have specifically filed a claim for survivor's loss benefits under the automobile policy. We disagree . . . Rather, we believe that all an insured could reasonably be expected or required to do is inform the insurer of the specific loss for which benefits are sought.
>
> In the alternative . . . the one year back rule should nevertheless be tolled for that period from which defendant knew or reasonably should have known that plaintiff was entitled to benefits under the automobile policy . . .

183 Mich. App. at 761-63.

The Court of Appeals for the Sixth Circuit committed reversible error with its clear misapplication of Michigan law. It failed to address the current state of notice law in Michigan, choosing instead to base its decision on a rule no longer followed in

that state. If this Honorable Court finds *Welton* controlling, it cannot ignore *Welton's* progeny. The appellate court also improperly overruled its own prior decision in *Norfolk & Western Railway Co. v. Auto Club Insurance Association,* 894 F.2d at 841 (6th Cir. 1990), while creating the unnecessarily prescriptive rule in the case at bar. Thus, the Court of Appeals has defied settled law at the state and federal level and in so doing has denied to an individual who respondents concede is mentally disabled benefits to which he is entitled.

Petitioners have complied with every requirement of the law necessary to make a valid claim for the benefits they seek. They followed each step set out by Michigan courts in the post-*Welton* cases to achieve tolling. By filing Mr. Wolff's long-term disability claim they supplied respondent LINA with complete notice of injury: the name and address of the claimant, the name of the person injured, and a description of the time, place and nature of the injury. They informed LINA of the specific loss for which they were seeking benefits. That is all which is needed to trigger tolling. There is no need, as the Court of Appeals for the Sixth Circuit posited, for petitioners to have made specific claims for benefits under the group personal accident and business travel accident policies. Since petitioners fulfilled all requirements necessary to toll the contractual period of limitations on the filingof their claim, the law requires they be allowed to proceed with those claims. Petitioners have obeyed the law; justice demands that this Honorable Court vindicate their efforts by granting a writ of certiorari and reversing the court of appeals.

II.

WHETHER THE SIXTH CIRCUIT'S DECISION IN THE CASE AT BAR WHOLLY VITIATES THE CONGRESSIONAL INTENT OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT, 29 U.S.C. § 1001 *et seq.*, BY PROTECTING THE INTERESTS OF THE INSURER AND EMPLOYER TO THE COMPLETE DETRIMENT OF THE PETITIONER-EMPLOYEE IN A CASE WHERE THE FACTS AND EQUITIES ARE CLEARLY WITH PETITIONER AND WHERE APPLICATION OF THE CONGRESSIONAL INTENT IS CLEARLY MANDATED.

In finding for the respondents, the Court of Appeals for the Sixth Circuit acted in a manner unjustified by the Employee Retirement Income Security Act's plain statutory language and stated Congressional intent. The appellate court found for respondents in a case where the facts and equities are clearly with petitioners and where the language of the statute and its legislative history demonstrate Congress' desire to prevent such decisions from being rendered.

In the case at bar, petitioner Richard Wolff, who is conceded by respondents to be mentally disabled from a brain injury suffered in the course of his employment, made a claim for ERISA benefits which Congress pledged to protect. Mr. Wolff paid for the benefits, J & H promised to provide them and LINA was compensated to provide the benefits. Respondents' sole rationale for not providing petitioners with the promised benefits was that Mr. Wolff applied for the benefits after lapse of the contractual period of limitations. They did not dispute that Mr. Wolff was brain injured and did not address the detrimental effect the injury had on his efforts to claim the subject benefits.

Despite these uncontroverted facts, the appellate court inexplicably held that "Mr. Wolff's condition could not have prevented him for making an application for the benefits he now seeks." *Wolff v. LINA*, 989 F.2d 501, 1993 U.S. App. LEXIS 6903 (1993). That court then held that "because appellants never made a claim for the particular policies at issue, we find that appellants failed to file their claims for benefits within the required three-year period." *Id.* at 6908. In so holding, the Court of Appeals for the Sixth Circuit abdicated its duty to affirmatively act to protect the pension benefits of individual workers as mandated by ERISA and acted in contravention of settled law.

The Court of Appeals for the Sixth Circuit based its decision, in part, on its interpretation and application of ERISA's provisions. Since this action is based on the interpretation and application of a federal statute, a federal question has been created that demands determination at the highest level. *A. C. Frost & Co. v. Coeur D'Alene Mines Corp.*, 312 U.S. 38 (1940). ERISA is Congress' regulatory scheme to protect employee pensions. It is comprehensive and far-reaching. *Harris Trust & Savings Bank v. John Hancock Mutual Life Insurance Co.*, 722 F. Supp. 998 (1989). In Congress' own words, ERISA exists "to protect . . . the interests of participants in employee benefit plans and their beneficiaries . . . by providing for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. § 1001(b); *Massachusetts v. Morash*, 490 U.S. 107 (1989). More specifically, it protects employees who rely upon promises of employers to provide welfare or pension benefits. 29 U.S.C. § 1001(a); S. Rep. No. 127, 93d Cong., 1st Sess. 1 (1973); *Lipscomb v. Transac, Inc.*, 749 F. Supp. 1128 (1990).

Most importantly, Congress enacted ERISA to ensure the continued well-being and security of employees by establishing standards of conduct, responsibility and obligations for those who administer employee benefit plans. *Sirkin v. Phillips Colleges*, 779

F. Supp. 751 (1991). The Court of Appeals for the Sixth Circuit ignored Congress' desire that employees such as Mr. Wolff be protected. To allow respondents to escape paying benefits to a mentally disabled employee is an obvious contradiction of what Congress intended ERISA to accomplish.

Senate Report No. 93-127 states that ERISA is intended to "strengthen and improve the protections and interests of participants and beneficiaries of employee pension welfare and benefit plans." 3 U.S. Code Cong. & Admin. News, 93rd Congress, 2d Session, 1974 Legislative History at 4838. ERISA's provisions address the issue of whether American workers will receive private pension plan benefits they have been led to believe would be theirs. Additionally, "the purpose of [ERISA] is to prescribe legislative remedies for the various deficiencies existing in private pension plan systems . . ." *Id.* at 4838. The appellate court at no time acknowledged petitioners' interests as Congress desired. Indeed, the Court of Appeals for the Sixth Circuit exhibited its vigor on behalf of those parties from which ERISA is designed to protect the employee. In effect the Court of Appeals summarily disposed of a question of fact concerning the effect Mr. Wolff's injuries played in the delay in the filing of his claims. Petitioners' interests simply have not been vouchsafed as Congress desired.

Congress also wanted to ensure that private pension plans perform effectively and equitably. *Id.* at 4840. Congress recognized a need for safeguards "sufficiently adequate and effective to prevent the numerous inequities to workers which have resulted in tragic hardship to so many." Workers need "a level of protection which will adequately protect their rights and just expectations." *Id.* at 4850. The result of the appellate court's decision is below that level of protection which Congress anticipated would occur under ERISA. The decision of the court of appeals has not provided any protection of petitioners' rights and just expectations.

Additionally, settled case law is plain and plentiful in describing what Congress intended ERISA to accomplish. ERISA was designed to protect the interests of participants in employee benefit plans. *Nachman Corp. v. Pension Benefit Guaranty Corp.*, 436 F. Supp. 1334, *reversed on other grounds*, 592 F.2d 947 (1977). ERISA was primarily designed to preserve the pension rights of the individual. *Gilliam v. Edwards*, 492 F. Supp. 1255 (1980). Congress wanted ERISA to defend the interests of the employee, not protect the interests of the employer and the insurance carrier at the expense of the benefits which the legislation was designed to ensure.

At every turn the appellate court fashioned a rebuttal to Mr. Wolff's arguments. With respect to four out of the six arguments urged by petitioners, the Court of Appeals had ample authority available to have decided in petitioners' favor. In each instant, it did not.

Petitioners first argued LINA was estopped to assert the contractual period of limitations because it had a duty to investigate its own records.The Court of Appeals held to the contrary, thereby disregarding *Welton v. Carriers Insurance Co.*, 421 Mich. 571 (1984) and its progeny.

Second, petitioners argued the period of limitations was not enforceable because of Mr. Wolff's mental disability. The appellate court erroneously and without basis concluded his condition "couldn't have prevented him from making an application . . ." *Wolff v. LINA*, 989 F.2d 501, 1993 U.S. App. LEXIS 6903 (1993). It is simply disingenuous to assert that Mr. Wolff voluntarily and knowingly applied for some benefits while simultaneously choosing not to pursue other benefits. All of the benefits for which application was made were at the specific written direction of J & H. It is no more noteworthy that Mr. Wolff had an attorney during a portion of the relevant period. If Mr. Wolff had no knowledge of the subject ERISA benefits, he could not have

alerted an attorney, hired for a different purpose, to attempt to collect those benefits.

Third, petitioners asserted that no prejudice to LINA existed or, in fact, was suffered by respondents, a position amply supported by applicable state law. This argument was disposed of on the theory of waiver. To the contrary, petitioners' motion for rehearing in the court of appeals discloses ample references in the record upon which the appellate court could have found an absence of waiver.

Fourth and finally, petitioners asserted assumption of duty by J & H in support of which the district court and the court of appeals had before them correspondence of J & H directed to Richard Wolff. This issue was summarily disposed of by a description of the letters as being "standarized form[s]." There has never been an assertion nor is there anything in the record upon which that factual assertion could rest.

In sum total, it is the very tenor of the opinion of the Court of Appeals which suggests that petitioners' position is meritorious. That opinion vitiates the intent of Congress to act as protector of the solitary employee, defies the act's legislative history and refutes ERISA's statutory language.

ERISA is a remedial statute. *LeFebre v. Westinghouse Electric Corp.*, 549 F. Supp. 1021, *reversed on other grounds*, 747 F.2d 197 (1982). Remedial statutes are to be liberally construed to effectuate their purposes. *Sirkin v. Phillips Colleges*, 779 F. Supp. at 754 (1991). This rule has had the support of the Supreme Court for more than a century. See *Insurance Co. v. Dunn*, 87 U.S. 214 (1873). Courts should liberally construe ERISA to protect benefit plan participants. *Sirkin v. Phillips Colleges*, 779 F. Supp. at 754 (1991). The appellate court did not interpret ERISA liberally in seeking to carry out its stated purpose of protecting the individual

against the assembled legal, financial and bureaucratic power of respondents; instead, that court sought to narrowly interpret the terms of the contract entered into between Mr. Wolff and respondents. The decision of the Court of Appeals for the Sixth Circuit should have parallelled the intent of ERISA which governs the contract entered into between the parties.

The Court of Appeals for the Sixth Circuit has abrogated the purpose of the Employee Retirement Income Security Act giving consideration only to narrow and questionable legal grounds to the sole benefit of respondents. In place of assuring petitioners a full and fair opportunity to claim the sum total of remedies due them, the appellate court closed the door to those remedies. The law and equities are so strongly in petitioners' favor that to let the decision of the Court of Appeals for the Sixth Circuit stand would be to pervert reason and logic.

CONCLUSION

The opinion of the Court of Appeals for the Sixth Circuit is inconsistent with stated Congressional intent, is contrary to the decision of the Court of Appeals for the Sixth Circuit in *Norfolk & Western Railway Co. v. Auto Club Insurance Association*, 894 F.2d 838 (1990) and is contrary to applicable and controlling state law directly on point. Therefore, petitioners respectfully request that this Honorable Court grant a writ of certiorari.

Respectfully submitted,

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APPENDIX A — UNITED STATES COURT OF APPEALS ORDER DENYING PETITION FOR REHEARING FILED APRIL 16, 1993

Case No: 92-1072

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

ORDER

RICHARD A. WOLFF; MARGUERITE M. WOLFF

Plaintiffs-Appellants

v.

LIFE INSURANCE COMPANY OF NORTH AMERICA, a Pennsylvania Corporation; JOHNSON & HIGGINS, a Foreign Corporation

Defendants-Appellees

BEFORE: KEITH and BATCHELDER, Circuit Judges; WELLFORD, Senior Circuit Judge

Upon consideration of the petition for rehearing filed by the appellant,

It is ORDERED that the petition for rehearing be, and it hereby is, DENIED.

ENTERED BY ORDER OF THE COURT

s/ Leonard Green
Leonard Green, Clerk

APPENDIX B — UNITED STATES COURT OF APPEALS DECISION FILED MARCH 23, 1993

NOT FOR PUBLICATION

92-1072

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

On Appeal from the United States District Court for the Eastern District of Michigan

RICHARD A. WOLFF, MARGUERITE M. WOLFF,

Plaintiffs-Appellants,

v.

LIFE INSURANCE COMPANY OF NORTH AMERICA and JOHNSON & HIGGINS,

Defendants-Appellees.

BEFORE: KEITH and BATCHELDER, Circuit Judges, and WELLFORD, Senior Circuit Judge.

PER CURIAM: Plaintiffs-appellants, Richard A. Wolff and Marguerite M. Wolff, appeal the district court grant of summary judgment in favor of defendants-appellees, Life Insurance Company of North America ("LINA") and Johnson & Higgins ("J&H"). In this cause of action, appellants seek payment of benefits under two insurance policies for injuries Mr. Wolff sustained in a fall that occurred while he was on a business trip. For the reasons stated below, we AFFIRM the district court's summary dismissal.

Appendix B

I.

This is an action for recovery of benefits under a group employee benefits plan (the "Plan"). The policies in question are a personal injury accident policy (No. ABL-61-36-06) and a business travel accident policy (No. OK-20-33). Premiums were paid on the business travel accident policy for all employees by Johnson & Higgins (J&H). Mr. Wolff purchased the personal injury policy through payroll deductions.

The facts are not in dispute. Richard Wolff worked as an account supervisor and a property loss consultant for J&H from June 1966 until he took an early disability retirement in September, 1980. On May 18, 1980, Mr. Wolff fell and struck his head while on a business trip in Kentwood, Michigan. As a result of this injury, Mr. Wolff suffered headaches and memory loss. These injuries have rendered Mr. Wolff permanently disabled.

Shortly after the accident, Mr. Wolff applied for and received long-term disability benefits under the J&H employee benefits plan. At approximately the same time, Mr. Wolff also applied for worker's compensation benefits. Mr. Wolff and J&H eventually settled the worker's compensation claim for seven thousand dollars ($7,000).

Appellants, however, did not file a written notice of their claim or proof of loss under either of the accident policies until January 10, 1989, almost nine years after Mr. Wolff's fall. On that date, plaintiffs submitted a proof of loss to LINA under both the group personal injury and business travel accident policies. Appellants contend that they did not remember, or were unaware of the insurance coverage under these two policies until December 1988, at which time Mr. Wolff reviewed his employee benefits handbook which outlined the various policy coverages. Both

insurance policies provide that a legal action may not be brought more than three years after the time a written proof of loss is required to be furnished. Written proofs of lost must be furnished within ninety days of the date of loss, or as soon thereafter as is reasonably possible.[1]

LINA denied appellants' claim for personal injury and accident benefits under the policies, finding insufficient evidence to establish that Mr. Wolff's disability arose solely from the accidental fall. Under LINA's insurance policies, if a policy holder's injury is proximately caused by a preexisting condition, that holder is ineligible to receive benefits. Both policies provide that LINA insures only "against loss resulting directly and independent of all other causes from accidental bodily injuries. . ." Mr. Wolff had several past medical problems, including a head injury suffered in World War II. A J & H benefits manager informed Mr. Wolff of this decision by letter dated February 5, 1990.

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1. The relevant policy provisions provide as follows:

> Notice of Claim: Written notice of claim must be given to the company within thirty (30) days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the company at Philadelphia, Pennsylvania or to any authorized agent of the company, with information sufficient to identify the insured, shall be deemed notice to the company
>
> Proofs of Loss: Written proof of loss must be furnished to the company at its said office within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible.

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On June 1, 1990, appellants filed a complaint in the Livingston County Circuit Court asserting a state-law breach of contract claim and a claim of violation of the Michigan Uniform Trade Practices Act [UTPA], M.C.L. 500.2001 et seq. Defendants-Appellees filed motions for summary judgment and dismissal.

The matter was referred to a magistrate. The magistrate found that "plaintiffs' claims against J&H are predicated solely upon the contention that the company owed them a duty to timely file the necessary notice or proofs of loss on their behalf". The magistrate concluded that the plaintiffs failed to state a claim upon which relief may be granted against J&H. With respect to LINA, the magistrate found that the appellants' claims were untimely, due to the three-year contractual limitation, and therefore, recommended granting summary judgment in favor of defendant-appellee, LINA.

The district court entered both an acceptance of the report and recommendation and a judgment in favor of defendants-appellees on December 13, 1991. This timely appeal followed.

On appeal, appellants bring several assignments of error. With regard to appellee LINA, plaintiffs maintain that the district court's summary judgment in favor of LINA should be vacated for three reasons. First, appellants claim that LINA should be estopped to assert the three-year contractual limitation because LINA had notice of appellants' claims by way of its duty to investigate its records to determine whether Mr. Wolff was insured under other insurance policies. Second, appellants argue that the three-year contractual limitation is not enforceable against Mr. Wolff because it was impossible for Mr. Wolff to notify the insurer due to mental disability. Finally, appellants maintain that LINA is obligated to pay benefits to Mr. Wolff since no prejudice resulted to LINA from

Mr. Wolff's delay.

With regard to J&H, appellants argue that the district court's summary judgment should be vacated because J&H owed appellants a duty to both advise them as to all available claims and to submit claims on their behalf. Appellants base this argument on theories of assumption of duty, agency, and J&H's statutory obligations under ERISA.

Appellants also argue that the district court abused its discretion in denying appellants' motion to amend the complaint to include a claim of negligence against J&H.

Each argument is addressed below seriatim.

II.

Appellants maintain that LINA had inquiry notice of their claims for recovery under the two insurance policies at issue and therefore cannot prevail upon the three year contractual limitation. The appellants are asking this court to require appellee, LINA, to investigate all other potential claims of recovery under any additional policies the claimant has with LINA, upon the filing of a claim by a policy holder. If this court finds that such a duty should be imposed, appellants argue that LINA is estopped from asserting the contractual period of limitations contained in the insurance policies at issue.

Although appellants did not submit a claim under either the personal accident policy or business travel policy until January 10, 1989, nearly nine (9) years after the date of the loss, they argue that LINA should be estopped from asserting lack of notice. Appellants

contend that LINA was in fact on notice of Mr. Wolff's injury due to Mr. Wolff's claim for long-term disability in 1980.

The Michigan Supreme Court addressed the inquiry notice argument in *Welton v. Carrier's Ins. Co.*, 365 N.W.2d 170 (Mich. 1984). In *Welton*, an insurance carrier provided the plaintiff's employer with both worker's compensation insurance and no-fault automobile insurance. The plaintiff was injured and submitted a worker's compensation claim, arguing that the filing of the worker's compensation claim provided sufficient notice to the carrier of the no-fault claim. The Michigan Supreme Court rejected plaintiff's argument, holding that the general notice of injury provided by the filing of the worker's compensation claim was insufficient to trigger tolling. The court stated:

> Notice of injury simply informs the insurer of 'the name and address of the claimant,' 'the name of the person injured and the time, place and nature of his injury'. M.C.L. 500.314(1); M.S.A. 24.13145(1). Until a specific claim is made, an insurer has no way of knowing what expenses have been incurred, whether those expenses are covered losses and, indeed, whether the insured will file a claim at all. It is therefore illogical to expect the insurer to formally "deny" an as yet unperfected claim.

Welton, 365 N.W.2d at 173.

Furthermore, in *Benson v. Home Ins. Co.*, 333 N.W.2d 43 (Mich. App. 1983), the court held that an insurance company does not have a duty to conduct a full-scale search of their records whenever an insured files a claim to determine whether the insured

may be covered under any additional policies. The *Benson* court stated:

> "[an] insurance company cannot be expected to investigate all potential claims merely because a claim unrelated to the plaintiff incidentally contains the information concerning the plaintiff's injuries. . ."

Benson, 333 N.W.2d at 45.

Therefore, in accordance with Michigan precedent, this court will not impose a duty upon LINA to conduct a search of its own records to determine whether a particular individual who files a claim is insured under other insurance policies.

Appellants also argue that the contractual period of limitations should not be enforced because it was impossible for Mr. Wolff to notify the insurer due to mental disability resulting from the accident giving rise to the claim. Appellants, however, have not put forth any evidence to raise a genuine factual question as to whether it was reasonably possible for him to have filed suit in a timely fashion.

Mr. Wolff testified that he received a letter in December, 1988 from J&H advising him of his eligibility for certain group benefits upon his official retirement. Subsequently, Mr. Wolff reviewed his Employee Benefits Handbook and realized that there was possibility of insurance benefits under these two insurance policies. The sole reason advanced by appellants for not filing suit within the time limit was that it was not until December, 1988 that Mr. Wolff read his employee benefits handbook and remembered that he had accident insurance coverage.

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Mr. Wolff's condition could not have prevented him from making an application for the benefits he now seeks, in light of the other actions he took during the relevant time period. In that three-year limitation period, appellant applied for retirement benefits, long term disability benefits and social security benefits and applied and sued for worker's compensation benefits. Additionally, Mr. Wolff was represented by an attorney for at least a portion of the three-year limitation period.

Therefore, because appellants failed to meet either the notice of claim or the proof of loss requirements of the policies, and because appellants never made a claim for the particular policies at issue, we find that appellants failed to file their claims for benefits within the required three-year period.

Next, appellants argue that, despite the fact that Mr. Wolff forgot he had coverage under the insurance policy, LINA, nonetheless, remains obligated to pay benefits owed to appellants since no prejudice resulted to LINA from Mr. Wolff's delay. Since appellants raise this argument for the first time on appeal, it is waived. *Taft Broadcasting Co. v. United States*, 929 F.2d 240, 243-244 (6th Cir. 1991).

III.

Appellants argue that J&H had a duty to advise appellants of all available benefits and to submit claims on appellant's behalf. Appellants assert this argument under the theories of assumption of duty, creation of agency, and J&H's statutory obligations under ERISA. We disagree.

Appellants' argument that J&H assumed a duty is based upon two letters sent by J&H to the appellants following the accident.

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The first letter, dated August 28, 1980, notified Mr. Wolff that he "may have a potential claim under our Long Term Disability program," as well as a claim for possible Social Security disability benefits. The letter did not state that these potential insurance claims were the only possible insurance claims Mr. Wolff was eligible for as a result of the head injury. The second letter, dated December 29, 1980, outlined benefits available "*specifically to you* as a retired employee of J&H" (emphasis in original). It was prompted by Mr. Wolff's retirement from J&H, and did not address plaintiff's injury.

Appellants maintain that through these letters, J&H assumed a duty to advise appellants and pursue all claims resulting from Mr. Wolff's injury and status as a retiree of J&H. In addition, appellants contend that J&H negligently breached that duty by failing to mention the two policies at issue.

The letters are, in fact, standardized form letters sent out by the benefit coordination office. Neither letter states that the benefits listed are the sole benefits for which Mr. Wolff may be eligible. Rather, the December 29, 1980, letter advised Mr. Wolff to examine the employee handbook for further information regarding benefits available and invited him to call the benefits coordinator for further assistance. Specifically, the letter stated: "As you probably realize, you are eligible to have certain benefits continue after you retire. These benefits are described in general terms in the handbook, 'Your Portfolio of Employee Benefits.' " Based upon these facts, it is clear that J&H did not assume a duty to advise or to pursue potential claims. Consequently, we conclude there could have been no negligence. *Munson v. Vane Stecker Co.*, 79 N.W.2d 855 (Mich. 1956) (an action claim for negligence requires a legal duty).

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Next, appellants argue that J&H had an agency relationship with either the appellants or the appellee-defendant, LINA, creating a duty to advise LINA of Mr. Wolff's injuries and to pursue all potential claims on appellants' behalf.

Generally, in order for an agency relationship to exist, a principle must give permission to the agent to act on the principal's behalf. In turn, the agent must consent to do so. *See Terbovitz v. Fiscal Court of Adair County, Ky.*, 825 F.2d 111, 116 (6th Cir. 1987).

Here, J&H is not an agent of LINA. The relationship between LINA and J&H is that of insured and insurer, as the policy indicates. J&H exercised no authority or control over decisions affecting the entitlement to or awarding of benefits. Instead, its duties under the plan were limited to providing certain administrative services for LINA, processing claims, and paying premiums for covered employees under the business accident policy. LINA, as the insurer carrier, had the sole authority to grant or deny benefits. Additionally, J&H has no power to bind LINA. All rights, decisions, and powers with respect to these policies were reserved by LINA. Under the express terms of the policies, the only power which J&H retained was the right to terminate the policy on its first anniversary date, or at any time thereafter.

In addition, J&H is not an agent of appellants. As stated above, J&H was never under any duty to make claims on behalf of appellants or to advise appellants as to potential claims. Accordingly, no agency relationship existed between appellant and J&H or between J&H and LINA.

Finally, appellants contend that, under the provisions of ERISA, J&H had a fiduciary duty to individually and personally

advise appellants regarding available accident benefits, due to the nature of Mr. Wolff's injury.

Under certain circumstances, an employer may be held to be an ERISA plan fiduciary. *See e.g., Moehle v. NL Industries, Inc.*, 646 F. Supp. 769 (E.D.Mo. 1986), *aff'd without opinion,* 845 F.2d 1027 (8th Cir. 1988). However, the fiduciary duties imposed on employers by ERISA under 29 U.S.C. § 1104 are fulfilled by issuing a "non-technical," "easy to read" plan summary booklet. *Allen v. Atlantic Richfield Retirement Plan,* 480 F. Supp. 848, 851 (E.D.Pa. 1979) *aff'd, without opinion,* 633 F.2d 209 (3d Cir. 1980). Here, appellants concede that Mr. Wolff had just such a booklet in his possession prior to his accident. In fact, it was through this booklet, that plaintiff learned of his benefits. Thus, J&H did not breach their fiduciary duties.

Furthermore, J&H had no involvement in the decision to deny appellants' claim and is, therefore, not a proper party to this suit for recovery of benefits under ERISA. *See Warren v. Oil, Chemical and Atomic Workers Union Industray Pension Fund,* 729 F. Supp. 563, 565-66 (E.D.Mich. 1989) (*citing Gelardi v. Pertec Computer Corp.*, 761 F.2d 1323 (9th Cir. 1985)). Since J&H did not owe plaintiffs a duty to file their benefit claims, the court below correctly dismissed for failure to state a claim upon which relief may be granted.

IV.

Appellants assert that the district court abused its discretion in denying an oral "motion" to amend the complaint to include a claim of negligence against J&H. The allowance of an amendment is within the discretion of the trial court. *Roth Steel Products v. Sharon Steel Corp.*, 705 F.2d 134, 155 (6th Cir. 1983). Such a

decision is reviewed only for abuse of that discretion. *See Zenith Radio Corp. v. Hazeltine Research*, 401 U.S. 321, 330-31 (1971); *Miller v. Metropolitan Life Insurance Co.*, 925 F.2d 979, 982 (6th Cir. 1991).

In deciding whether to accept an amendment of pleadings, the district court is permitted to consider a number of factors including: undue delay, lack of notice to the opposing party, repeated failure to cure deficiencies by previous amendments, undue prejudice to the opposing party, and futility of amendment. *See Robinson v. Michigan Consolidated Gas Co., Inc.*, 918 F.2d 579, 591 (6th Cir. 1990). If the court finds one or more of these factors present, it may deny a party's motion to amend a pleading.

An examination of the record reveals, first, that no motion to amend was ever filed, and it is questionable whether the language in the record that appellants contend was their motion constitutes a motion at all. However, even assuming a motion was made, the district court did not abuse its discretion when it denied appellants' motion to amend the complaint because the granting of the motion would have resulted in undue delay. The issue of negligence was discussed by appellants in their combined brief in response. In fact, the court's findings as to the lack of this duty on the part of J&H formed a basis for this appeal. Thus, irrespective of the court's actions, appellants were given the opportunity to be heard in regard to the negligence claim and the claim was evaluated on the merits. Accordingly, this assignment of errors fails.

V.

For the reasons stated above, we AFFIRM the decision of the Honorable Stewart A. Newblatt, United States District Judge for the Eastern District of Michigan.

APPENDIX C — UNITED STATES DISTRICT COURT'S JUDGMENT FILED DECEMBER 10, 1991

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION — FLINT

CIVIL NO.: 90-CV-40196-FL

HON. STEWART A. NEWBLATT

RICHARD A. WOLFF and MARGUERITE M. WOLFF,

Plaintiffs,

vs.

LIFE INSURANCE COMPANY OF NORTH AMERICA, a Pennsylvania Corporation, and JOHNSON & HIGGINS, a Foreign Corporation,

Defendants.

JUDGMENT

The Court has reviewed the file, the Magistrate's Report and Recommendation, and any timely objections filed thereto.

Now, therefore, IT IS ORDERED AND ADJUDGED that the Defendant Johnson & Higgins' motion to dismiss be and hereby is GRANTED and it is dismissed as a defendant. IT IS FURTHER ORDERED that Defendant LINA's motion for summary judgment be and hereby is GRANTED as to all claims and it is dismissed as a defendant.

IT IS FURTHER ORDERED that the Clerk serve a copy of this Judgment by United States mail on the counsel for Plaintiff and on the counsel for Defendant.

Appendix C

s/ Stewart A. Newblatt 12/16/91
STEWART A. NEWBLATT
UNITED STATES DISTRICT JUDGE

Date: 12/10/91
Flint, Michigan

APPENDIX D — UNITED STATES DISTRICT COURT'S ORDER ACCEPTING MAGISTRATE'S REPORT AND RECOMMENDATION FILED DECEMBER 10, 1991

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION — FLINT

CIVIL NO.: 90-CV-40196-FL

HON. STEWART A. NEWBLATT

RICHARD A. WOLFF and MARGUERITE M. WOLFF,

Plaintiffs,

vs.

LIFE INSURANCE COMPANY OF NORTH AMERICA, a Pennsylvania Corporation, and JOHNSON & HIGGINS, a Foreign Corporation,

Defendants.

ORDER ACCEPTING MAGISTRATE'S
REPORT AND RECOMMENDATION

The Court having reviewed the Magistrate's Report and Recommendation, filed on September 9, 1991, as well as any objections filed thereto,

IT IS ORDERED that the Report is accepted and entered as the findings and conclusions of this Court.

s/ Stewart A. Newblatt 12/10/91
STEWART A. NEWBLATT
UNITED STATES DISTRICT JUDGE

Dated: 12/10/91

APPENDIX E — REPORT AND RECOMMENDATION OF THE UNITED STATES MAGISTRATE FILED SEPTEMBER 9, 1991

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION — FLINT

CIVIL NO.: 90-CV-40196-FL

HON. STEWART A. NEWBLATT

RICHARD A. WOLFF and MARGUERITE M. WOLFF,

Plaintiffs,

vs.

LIFE INSURANCE COMPANY OF NORTH AMERICA, a Pennsylvania Corporation, and JOHNSON & HIGGINS, a Foreign Corporation,

Defendants.

REPORT AND RECOMMENDATION

This is an action for recovery of benefits under a group employee benefits plan [the "Plan"]. Plaintiffs, Richard Wolff and his wife, Marguerite, seek payment of benefits under two insurance policies for injuries Mr. Wolff sustained in a fall that occurred while he was on a business trip. Named as defendants are Johnson & Higgins Corporation [J&H], Mr. Wolff's employer at the time of the accident, and Life Insurance Company of North America [LINA], the insurer on the two policies at issue. The

policies in question are a personal injury accident policy (No. ABL-61-36-08) and a business travel accident policy (No. OK-20-33). Premiums were paid on the business travel accident policy for all employees by Johnson & Higgins. On the other hand, each employee had an option to purchase the personal injury policy through payroll deductions, an option exercised by Mr. Wolff.

The facts are not in dispute. Richard Wolff worked as an account supervisor and loss control consultant for J&H for fourteen years; from June, 1966 until he took an early disability retirement in September, 1980. On May 18, 1980, Mr. Wolff fell and suffered a head injury while on a business trip in Kentwood, Michigan. The head injury has resulted in headaches and memory loss. The injuries from the fall have rendered Mr. Wolff totally and permanently disabled.

Shortly after the accident, Mr. Wolff applied for and received long-term disability benefits available under the J&H employee benefits plan. At approximately the same time, Mr. Wolff also applied for worker's compensation benefits. This claim was eventually settled with J&H for Seven Thousand Dollars [$7,000.00].

However, plaintiffs did not file a written notice of claim or proof of loss under either accident policy until January 10, 1989, almost nine years after the fall. On that date, plaintiffs submitted a proof of loss to LINA under both the group personal injury and business travel accident policies. Plaintiffs contend that they did not remember, or were unaware, of the insurance coverage under these two policies until December, 1988, when Mr. Wolff reviewed his employee benefits handbook which outlined the various policy coverages.

Appendix E

LINA denied plaintiff's claims for personal injury and accident benefits, finding the evidence insufficient to establish that Mr. Wolff's disability arose solely from the accidental fall. Under the policies, if the injury was proximately caused by a preexisting condition plaintiff would have been ineligible for benefits under the policies.[1] J&H's Benefits Manager informed Mr. Wolff of this decision by letter dated February 5, 1990.

On June 1, 1990, plaintiffs filed a complaint in the Livingston County Circuit Court asserting a state-law breach of contract claim and a claim of violation of the Michigan Uniform Trade Practices Act [UTPA], M.C.L. § 500.2001 *et. seq.* Defendants removed the case to this court pursuant to 28 U.S.C. § 1441(b), asserting that the complaint alleged a federal question under the Employee Retirement Income Security Act of 1974 [ERISA], 29 U.S.C. § 1001 *et. seq.*[2]

Count I of the complaint alleges that J&H breached its duty to file a timely claim for benefits on plaintiffs' behalf under the two

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1. Both policies provide that LINA insures only against loss resulting directly and *independent of all other causes* from accidental bodily injuries. . . ." Mr. Wolff had several past medical problems, including a head injury suffered in World War II.

2. Although Count I was originally brought solely as a state common law claim for breach of contract, plaintiff's complaint should not be dismissed on the basis of ERISA preemption. Plaintiffs do not dispute the fact that the cause of action "relate[s] to [an] employee benefit plan" and is preempted by ERISA, 29 U.S.C. § 1144. *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987), citing *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987). Instead, they now seek to allege a direct claim for benefits under ERISA. Accordingly, Count I will be addressed solely as an ERISA-based claim for recovery of benefits under 29 U.S.C. § 1132. *See Nolan v. Aetna Life Ins. Co.*, 588 F.Supp. 1375 1377-78 (E.D.Mich. 1984) [reaching claim despite failure to allege an ERISA violation in complaint]. *See also, Ruble v. UNUM Life Ins. Co.*, 913 F.2d 295,297-98 (6th Cir. 1990).

policies and that defendant LINA wrongfully refused to pay those benefits to which plaintiffs are entitled. In Count II, plaintiffs further contend that both defendants acted in violation of their rights under the Michigan UTPA and seek to recover the 12 percent interest penalty the Act provides when "claims [are] not paid on a timely basis." M.C.L. § 500.2006(1).

Defendants have filed motions to dismiss the complaint pursuant to Fed.R.Civ.P. 12(b)(6), or in the alternative, for summary judgment under F.R.Civ.P. 56. A number of arguments are raised in support of their respective motions. Initially, J&H asserts that since it was not a party to the insurance contract and had no other legal duty to plaintiffs, it cannot be held liable. Both J&H and LINA assert that because suit was filed more than ten years after plaintiffs' claims accrued, the action is barred by the applicable statute of limitations. Both defendants also contend that since plaintiffs' claims are governed by ERISA, dismissal is required because plaintiffs have failed to exhaust the administrative remedies provided under the Plan. Finally, each defendant maintains that it is entitled to summary judgment as a matter of law because of plaintiffs' failure to comply with the requirements of the policies.

DEFENDANT JOHNSON & HIGGINS

Plaintiffs' claims against J&H are predicated solely upon the contention that the company owed them a duty to timely file the necessary notice or proofs of loss on their behalf. Plaintiffs argue that this is especially the case where, as here, J&H knew that Mr. Wolff had suffered serious brain damage. However, for the reasons that follow, I conclude that plaintiffs have failed to state a claim upon which relief may be granted against this defendant and accordingly recommend that J&H be dismissed as a defendant.

Appendix E

There is simply no support for plaintiffs' contention that J&H was under a contractual duty to submit claims to LINA on their behalf. To the contrary, the Plan specifically states that it is the obligation of the insured to take those steps necessary to perfect a claim for benefits. Assistance from the J&H Benefits Manager is available, but only upon request.[3] Moreover, J&H is not a party to the insurance contracts in issue. Only plaintiffs and LINA are parties to the contract. It necessarily follows that J&H cannot be sued for acts or omissions allegedly in breach of those contracts.

Plaintiffs further contend that J&H breached its fiduciary duties under ERISA by not filing their claims. This contention is also without merit. ERISA imposes liability on an employer only when and to the extent that the individual or entity exercises discretionary authority or control over the management of the plan or disposition of its assets. 29 U.S.C. § 1002(21)(A). Nowhere does the Act provide that an employer and/or plan administrator is under a fiduciary duty to submit claims on behalf of a plan participant. Similarly, ERISA does not impose any fiduciary duty to ensure that each employee is personally informed of the various benefits to which they may be entitled as a result of an accident or injury. *See Allen v. Richfield Retirement Plan*, 480 F.Supp. 848 (E.D.Penn. 1979), *aff'd. without opinion*, 633 F.2d 209 (3d Cir. 1980).

While an employer may be held to be an ERISA plan fiduciary under certain circumstances, *see e.g., Moehle v. NL Industries*, 646 F.Supp. 769 (E.D.Mo. 1986), *aff'd. without opinion*, 845 F.2d 1027 (8th Cir. 1988), such is not the case here. It is beyond contravention that J&H exercised no authority or control over decisions affecting

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3. Defendant states, and plaintiffs do not dispute, that plaintiffs did not contact a benefits representative for assistance in filing these claims until 1989.

the entitlement to or awarding of benefits. Instead, its duties under the plan were limited to providing certain administrative services for LINA, processing claims, and paying premiums for covered employees under the business accident policy. *See, e.g., Baxter v. Muer Corp., et. al*, No.90-1806, Slip Op. (6th Cir. August 13, 1991) [available on WESTLAW, 1991 WL 151518] (no factual or legal basis for ERISA suit against employer who was not a plan fiduciary). Under the express terms of the policies, the only power which J&H retained was the right to terminate the policy on its first anniversary date, or at any time thereafter. LINA, as the insurance carrier, had the sole authority to grant or deny benefits.

As J&H had absolutely no involvement in the decision to deny plaintiffs' claims, it is not a proper party to this suit for recovery of benefits under ERISA. *See Warren v. Oil, Chemical and Atomic Workers Pen.F.*, 729 F.Supp. 563,565-66 (E.D.Mich. 1989), citing *Gelardi v. Pertec Computer Corp.*, 761 F.2d 1323 (9th Cir. 1985). *See also, St. Mary Med'l Center v. Cristiano*, 724 F.Supp. 732,741 (C.D.Cal. 1989). Because the company owed plaintiffs no duty to file their benefit claims, dismissal is warranted for failure to state a claim upon which relief may be granted.

DEFENDANT LINA

1. Exhaustion

LINA seeks dismissal of the complaint due to plaintiffs' failure to exhaust the internal remedies available under the terms of the J&H employee benefits plan. In response, plaintiffs contend that they were not made aware of an appeal procedure and therefore were under no duty to exhaust.

Although ERISA does not contain a provision explicitly

requiring the exhaustion of internal remedies, it has generally been held that a plaintiff's ERISA claims are barred unless he first exhausts available administrative grievance procedures. *Baxter v. Muer Corp., et. al.*, No.90-1806, Slip Op. (6th Cir. August 13, 1991); *Miller v. Metropolitan Life Ins. Co.*, 925 F.2d 979,986 (6th Cir. 1991); *Makar v. Health Care Corp. of Mid Atlantic*, 872 F.2d 80,82 (4th Cir. 1989). *See also, Mason v. Continental Group Inc.*, 763 F.2d 1219,1226-27 (llth Cir. 1985), *cert. denied*, 474 U.S. 1087 (1986); *Kross v. Western Electric Co.*, 701 F.2d 1238,1243-45 (7th Cir. 1983); *Amato v. Bernard*, 618 F.2d 559,567 (9th Cir. 1980).[4] However, it must be noted that the exhaustion requirement is not absolute. For example, where any effort to appeal the adverse decision would be futile, an exception to the requirement exists. *Amato*, 618 F.2d at 568.

It is undisputed that the plaintiffs did not pursue the remedies provided under the Plan prior to bringing suit in this court. The Plan provides that where a claim is denied, the insured should send a written request for review to the J&H Benefits Manager, who will in turn forward it to LINA. That request for review should include both the reasons for disagreement with the decision and supplementary data or information. If the conflict remains unresolved, the insured may then be entitled to a meeting with the insurance company. *See* Defendant LINA's Motion for Summary Judgment/Dismissal, Exhibit H.

The Plan further provides, however, that in notifying a participant of the decision to deny benefits, the notice of denial *must* explain the procedure for requesting review of the denied

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4. In *Baxter, supra*, the Court of Appeals for the Sixth Circuit noted that the decision whether to require exhaustion in a given case is generally committed to the sound discretion of the district court.

claim, based on the established rules for the particular plan. The notice sent to plaintiffs was clearly deficient in this regard. Indeed, there is absolutely nothing in the February 5, 1990 letter from Linda Branon denying the claims which even hints at an appeal process.

LINA failed to comply with its own procedures for the denial of claims. It cannot now claim that plaintiffs' failure to exhaust warrants dismissal. I therefore suggest that the motion to dismiss for failure to exhaust internal remedies be denied. *See Cristiano,* 724 F.Supp. at 740-41; 29 C.F.R. 2560.503-1(f) [notice must contain appropriate information as to the steps to be taken if participants wish to submit a claim for review].

2. Statute of Limitations

Next, LINA contends that under either the three-year limitations period contained in Section 413 of ERISA, 29 U.S.C. § 1113(a)(2), or the six-year Michigan statute of limitations [M.C.L. 600.5807(8)] the action is time-barred because plaintiffs did not bring suit until more than ten years after Mr. Wolff's injury. ERISA does not contain a statute of limitations governing actions for recovery of benefits under section 502. It is well settled that in such cases the three-year period of limitation found in section 413 of the Act is inapplicable and the courts must instead look to the most closely analogous state statute of limitations. *Central States S.E. and S.W. Areas Pension Fund v. Kraftco Inc. and Teamsters,* 799 F.2d 1098,1105 (6th Cir. 1986) [en banc], *cert. denied,* 479 U.S. 1086 (1987); *Nolan v. Aetna Life Ins. Co.,* 588 F.Supp. 1375,1378 (E.D.Mich. 1984). *See also Fogerty v. Metropolitan Life Ins. Co.,* 850 F.2d 430,432 (8th Cir. 1988). The caselaw is also plain that an action for recovery of benefits under an ERISA-regulated employee benefit or pension plan is "most analogous" to

an action for breach of contract. *Central States*, 799 F.2d at 1378; *Nolan*, 588 F.Supp. at 1379; *Fogerty*, 850 F.2d at 432. *See also Jenkins v. Local 705 International Brotherhoood of Teamsters Pension Plan*, 713 F.2d 247,252-53 (7th Cir. 1983). Thus, Michigan's six-year statute of limitations for breach of contract is the controlling limitations period. MCL 600.5807(8).

Of course, whether plaintiffs' claims are barred by this sixyear limitations period depends on when the cause of action accrued.[5] According to defendant, plaintiffs' complaint is untimely because the cause of action accrued on May 18, 1980, the date of Mr. Wolff's fall. Plaintiffs agree that their cause of action accrued on the date of injury, but argue that the complaint was timely filed because the statute of limitations was tolled until LINA denied their claim for benefits in February, 1990.

The arguments of both parties, however, are based on a fundamental misconception. A cause of action accrues under federal law when a plaintiff becomes aware, or reasonably should become aware, of the facts underlying his or her claim. *Connors*, 935 F.2d at 342. In this case, plaintiffs' claims against LINA stem solely from the insurer's refusal to pay benefits. Indeed, the Wolffs could have become aware of their claim for benefits only at the time they received notice of the defendant's refusal to pay benefits. Thus, plaintiffs' cause of action accrued when the payment of benefits was denied, *not* on the date of Mr. Wolff's injury. *See Klein*

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5. Although courts generally determine the applicable limitations period by borrowing from state law, federal law controls the determination of the time at which the cause of action accrued. *Northern Cal. Retail Clerks Union v. Jumbo Markets*, 906 F.2d 1371,1372 (9th Cir. 1990) [action for violations of § 515 of ERISA, 29 U.S.C. § 1145, obligating employers to contribute to their employee benefit plansl. *See also, Connors v. Hallmark & Son Coal Co.*, 935 F.2d 336,341 (D.C.Cir. 1991) [cases cited therein].

v. John Hancock Mut. Ins. Co., 683 F.2d 358,360 (11th Cir. 1982) [although disability of the insured is a condition precedent of the insurer's responsibility to pay benefits, it does not form the basis for the cause of action]. *See also, Rodriguez v. Meba Pension Trust,* 872 F.2d 69,72 (4th Cir.), *cert. denied,* 110 S.Ct. 202 (1989) [a cause of action under ERISA does not accrue, for statute of limitations purposes, until a claim of benefits has been made and formally denied].

LINA notified plaintiffs that it was denying insurance benefits in a letter dated February 5, 1990. Since plaintiffs brought suit within four months of this date, the action is not barred by the applicable statute of limitations. Accordingly, defendant's motion for dismissal on this basis should be denied.

3. Contractual Limitations Period

LINA next contends that summary judgment should be entered in its favor because of plaintiffs' failure to comply with the terms of the two insurance policies. More specifically, LINA asserts that plaintiffs failed to file a timely notice of claim or proof of loss, and further did not bring suit within the time limit set forth in the policies.

Both insurance policies provide that a legal action may not be brought more than three years after the time a written proof of loss is required to be furnished. Written proofs of loss must be furnished within ninety days of the date of loss, or as soon thereafter as is reasonably possible.[6] Mr. Wolff's loss occurred on May 18, 1980.

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6. The relevant policy provisions provide as follows:

Notice of Claim: Written notice of claim must be given

(Cont'd)

Consequently, plaintiffs were required to have filed their complaint in August of 1983 in order for the action to be timely. However, this suit for recovery of benefits was not commenced

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(Cont'd)

> to the Company within thirty days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the Company at Philadelphia, Pennsylvania, or to any authorized agent of the Company, with information sufficient to identify the insured, shall be deemed notice to the Company.
>
> * * *
>
> **Proofs of Loss**: Written proofs of loss must be furnished to the Company at its said office within ninety days after the date of such loss. Failure to furnish such proof shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible.
>
> **Legal Actions:** No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

See Defendant Johnson & Higgins' Motion for Summary Judgment, Exhibits A & B. It should be noted that the inclusion of each of these provisions is made mandatory by statute in Michigan. *See* M.C.L. § 500.3412, 500.3414, 500.3422.

until June 1, 1990, almost seven years later.[7]

I conclude that the three-year limitation period contained in both policies bars plaintiffs' claims as a matter of law. On at least two occasions, courts in this judicial district have recognized the binding effect of such a suit limitation or "legal action" clause in an insurance contract. *See Gipson v. Life Ins. Co. of North America*, 529 F.Supp. 224 (E.D.Mich. 1981) [Feikens, J.]; *Roberson v. Metropolitan Life Ins. Co.*, 682 F.Supp. 907 (E.D.Mich. 1988) [Taylor, J].[8] *Gipson* involved an action for recovery of benefits under a disability insurance policy. In that case, unlike the case at bar, the plaintiff filed a timely proof of loss with the insurer. However, the plaintiff did not file suit to recover under the policy until almost six years after her claim for benefits was denied.

The court granted the defendant's motion for summary judgment, finding the action time-barred. A provision in the policy specifically limited the time in which a legal action may be brought to three years after written proof of loss was required to be furnished. Since the suit in question was filed almost three years beyond the limit legally provided by the policy, the court concluded that it had no choice but to enter judgment in favor of the insurer.

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7. As defendant correctly points out, the plaintiffs' seven year delay in filing suit precludes the them from taking advantage of the quoted clause in the policy allowing for notice to be given "as soon as reasonably possible."

8. Michigan courts have also followed the general rule that a clause in an insurance policy limiting the period within which suit may be brought is a valid contractual obligation and acts as a bar to any recovery by the insured where the deadline is not met. *See Bashans v. Metro Mut. Ins. Co.*, 369 Mich. 141,143 (1963); *Hall v. Metropolitan Life Ins. Co.*, 274 Mich. 196 (1936); *Lombardi v. Metropolitan Life Ins. Co.*, 271 Mich. 265 (1935); *Traverse City Bank v. Ranaer Ins. Co.*, 72 Mich.App. 150 (1976).

Similarly, in *Roberson*, the court was presented with a breach of contract action in which the plaintiff sought to recover sickness and accident benefits from an insurer which had issued a group policy to the plaintiff's employer. As in *Gipson*, the court, in an opinion by Judge Anna Diggs Taylor, found that plaintiff's claims for sickness and accident benefits were barred by the threeyear suit limitation provision contained in the insurance policy.[9] Explaining its ruling, the court wrote:

> Plaintiff was required to file proof of his claim for S&A benefits within 90 days after January 26, 1983, the maximum 1 year period for which S&A benefits are payable under the policy. Any lawsuit claiming entitlement to benefits, therefore, must have been filed within 3 years thereafter, or by April 26, 1986. Since this action was commenced in August of 1987, outside the limitations period, Plaintiff's claims for S&A benefits must be dismissed in their entirety.

682 F.Supp. at 909. While those cases are not binding, they are clearly persuasive. I, too, conclude that plaintiffs' claims against defendant LINA should be dismissed in their entirety because of plaintiffs' failure to file suit within the contractually-mandated time period.

Plaintiffs seek to avoid application of this rule by claiming that LINA should be estopped from invoking the suit limitation clause as a defense. Plaintiffs place considerable emphasis on a

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9. The court alternatively found that plaintiff's claims were preempted by both ERISA and the Labor Management Relations Act of 1947, 29 U.S.C. § 185.

clause contained in both insurance policies which provides that notice "to any authorized agent of the Company, with information sufficient to identify the Insured, shall be deemed notice to the Company." Plaintiffs argue that J&H was an agent of LINA and that by giving notice to J&H on the day of the injury, they fulfilled their obligations to LINA.[10]

However, beyond reciting the relevant contractual language, plaintiffs have no evidence establishing an agency relationship between J&H and LINA. To the contrary, my review of the contract indicates that the opposite is true. J&H, as a company which administered its employee group health plan, was simply the intermediary between the insurer and its thousands of insured employees. There is no evidence that J&H had any power to bind LINA, a prerequisite to a finding of agency between the two defendants. Instead, its role was clearly limited to the processing of claims made by an insured.

Plaintiffs also allege that LINA should be estopped from asserting that it was without notice because it was aware of Mr. Wolff's brain injury by way of plaintiffs' claim for long-term disability benefits in 1980. There appears to be no federal case considering this argument. However, the Michigan Supreme Court has explicitly rejected the type of "bootstrapping" argument advanced by plaintiffs in finding that a specific claim for benefits and *not* a general notice of injury is necessary to meet the notice requirements of an insurance policy. *See Welton v. Carriers Insurance Company,* 421 Mich. 571, 365 N.W.2d 170 (1985). *See*

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10. Significantly it should be noted that if, as plaintiffs seek to allege, they gave notice to Johnson & Higgins immediately after the accident, then their cause of action accrued in May, 1980 and would be barred by the applicable six-year statute of limitations.

also, Benson v. Home Insurance Company, 123 Mich.App. 626 (1983). As explained in *Welton*, it is entirely unreasonable to expect an insurance company to investigate all potential claims which may arise from an accident or injury. Until a specific request for benefits under a policy is made by an insured, there is no basis on which the company can decide whether to pay or deny the claim. 365 N.W.2d at 173. I find this reasoning persuasive. Plaintiffs' position would lead to a virtually impossible burden on insurance companies which I am unwilling to impose.

Finally, there is no suggestion in the record of any misleading or deceptive conduct on the part of either defendant which may have caused the delay in filing suit. Rather, the only reason advanced by plaintiffs for not filing suit within the time limit set forth in the policies is that it was not until December, 1988 that Mr. Wolff read his employee benefits handbook and remembered that he had accident insurance coverage.

While the seriousness of Mr. Wolff's condition is not to be discounted or minimized in anyway, the seven-year delay in filing suit in this case cannot reasonably be excused on the basis of his alleged mental incapacity. Before the limitations period had run, plaintiffs had already retained the services of an attorney. *See e.g., Troutman v. State Farm Fire & Cas. Co.,* 570 F.2d 658 (6th Cir. 1978). With or without the lawyer's assistance, plaintiffs were able to file timely claims for long-term disability and worker's compensation benefits. Plaintiffs would have been aware of the insurance policies in question if they had read the employee benefits handbook which they concede was in their possession at the time of the accident. Indeed, it was Mr. Wolff himself who discovered that he was potentially entitled to the benefits he now seeks to recover, albeit seven years too late. His failure to read the handbook at an earlier date is an unavailing excuse.

In short, plaintiffs' action is governed by the three-year limitations period contained in the insurance contracts. As plaintiffs failed to seek benefits within the time provided, their action against the insurer should be barred as untimely. Accordingly, I recommend that defendant LINA is entitled to summary judgment as a matter of law.

UNIFORM TRADE PRACTICES ACT

Initially, it appears that plaintiffs' action for damages under the Michigan UTPA is preempted by ERISA and would likely be subject to dismissal on this basis alone. However, I need not reach this determination in the present case as plaintiffs' claims against both defendants under the UTPA are more easily resolved. By seeking to recover the 12 percent interest penalty the Act provides for, plaintiffs are merely alleging an additional cause of action arising from the insurer's refusal to pay benefits. Because it has already been determined that plaintiffs cannot recover against either J&H or LINA under the insurance contracts, they no longer have any cause of action against the defendants under the UTPA. This particular claim should be dismissed as moot.

CONCLUSION

For the reasons stated herein, I respectfully recommend that defendant Johnson & Higgins' motion to dismiss be GRANTED as to all claims against it. I further recommend that defendant LINA's motion for summary judgment be GRANTED as to all claims and that it, too, be dismissed as a defendant.

Pursuant to Rule 72(b) of the Federal Rules of Civil Procedure and 28 U.S.C. § 636(b)(1), the parties are hereby notified that within ten days after being served with a copy of this

recommendation they may serve and file specific, written objections to the proposed findings and recommendations. Further, either party may respond to another party's objections within ten days after being served with a copy thereof. The parties are further informed that failure to timely file objections may constitute a waiver of any further right of appeal to the United States Court of Appeals. *United States v. Walters*, 638 F.2d 947 (6th Cir. 1981).

s/ Marc L. Goldman
MARC L. GOLDMAN
UNITED STATES MAGISTRATE JUDGE

Date: September 9, 1991

APPENDIX F — LETTER OF AUGUST 28, 1980 FROM JOHNSON AND HIGGINS TO RICHARD WOLFF

JOHNSON & HIGGINS

Established 1845

INSURANCE BROKERS – AVERAGE ADJUSTERS

ACTUARIES – EMPLOYEE BENEFIT PLAN CONSULTANTS

August 28, 1980

Mr. Richard M. Wolff
51115 Red Fox Drive
Brighton, MI 48116

Dear Richard:

You may have a potential claim under our Long Term Disability program.

INA Life Insurance Company of New York is our carrier for this coverage. Enclosed is a copy of their form GB 4A67. You should complete Section II. Please ask your doctor to complete the "Attending Physician's Statement" on the reverse side and return the form to me in the enclosed envelope. We can then complete the employer's section and send it on to the insurance company. Please do this as soon as you can so that INA starts whatever processing they require.

In addition, you may qualify for Social Security disability benefits, if you do qualify these benefits can begin after five

Appendix F

months of total disability. You should apply at your local office of the Social Security Administration.

Call anytime we can help (212 482-2412).

Sincerely,

s/ Elaine
Elaine M. Justus
Assistant Vice President

encls
emj/mmw

APPENDIX G — LETTER OF DECEMBER 29, 1980 FROM JOHNSON AND HIGGINS TO RICHARD WOLFF

JOHNSON & HIGGINS

Established 1845

INSURANCE BROKERS – AVERAGE ADJUSTERS

EMPLOYEE BENEFIT PLAN CONSULTANTS

December 29, 1980

Mr. Richard M. Wolff
5115 Red Fox
Brighton, Michigan 48116

Dear Dick:

On the occasion of your retirement from Johnson & Higgins on October 1, 1980, we would like to extend sincere good wishes to you.

As you probably realize, you are eligible to have certain benefits continue after you retire. These benefits are described in general terms in the handbook, "Your Portfolio of Employee Benefits."

At this time, we are pleased to outline, below, the benefits that apply *specifically to you* as a retired employee of J&H:

Group Medical & Dental Coverage

J&H will continue regular medical coverage for you until you are age 65. Then our plan, in conjunction with Medicare Parts A and B,

will provide exactly the same benefits available as before your eligibility for Medicare but with a lifetime maximum of $100,000. Johnson & Higgins pays for the cost of your coverage. Your wife will be protected by the regular J&H coverage up to the time she becomes eligible for Medicare. You pay the regular J&H contribution previously deducted from your pay checks. After your wife is eligible for medicare we will provide the same coverage as we are now providing for you in conjunction with Parts A and B of Medicare with a lifetime maximum of $100,000. You will continue to be billed for the same amount you are currently paying for her coverage. You can discontinue this coverage at anytime, if you choose, simply by not paying the premium. It is your responsibility and that of your wife to enroll for Part B of Medicare.

Your dental insurance stops when you are age 65. You can continue dental insurance for your wife until she reaches age 65 by paying the same amount that was previously deducted from you pay checks. You will be billed annually for the cost of these coverages. A bill covering the period October 1, 1980 through the end of 1981 is enclosed. Please return it to the Finance Department together with your check.

Group Life Insurance

J&H will continue 20% of the group life insurance for which you are covered immediately before you retired. Enclosed is a certificate for life insurance in the amount of $4,000.00.

Survivor Income, Long Term Disability & Personal Accident Insurance

These coverages stop at retirement.

Appendix G

J&H Profit Sharing Plan

There were 20,217.47 units to your credit in the fixed income fund as of December 31, 1979. You have elected to receive the value of these units in a lump sum. Based on the November 30, 1980 unit values your account is worth $30,188.73. Your payout will be based on the November 30, 1980 united values. It will be mailed to you direct from the Trustee and should be received around the end of December 1980.

Your pro-rated share of the 1980 contribution will be made early in January of 1981 and will be paid to you as of the February 28, 1981 unit values. You will receive this additional contribution during early to mid-April of 1981.

Retirement Income Plan

You have elected to receive your retirement income in the form of a 50% Joint and Survivor annuity with your wife, Marguerite, as joint annuitant.

Enclosed is Aetna Life Insurance Company check number 08539013 dated December 12, 1980 payable to you in the amount of $413.25. This check covers the period from October 1, 1980 through December 1, 1980. All future checks in the amount of $137.75 will be sent directly to your home by Aetna.

Should you predecease your wife, $68.88 would continue to her for as long as she lives.

Enclosed also is Aetna Life Insurance Company Annuitant's Notice describing the mode of annuity payments.

Appendix G

Should you have any questions — now or in the future — just let us know.

Sincerely,

s/ Elaine
Elaine M. Justus
Assistant Vice President

EMJ:mlr
encls.

bcc: Mr. R. L. Hannon, Jr.
J&H Detroit